Washington State Health Care Authority

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ProviderOne
Washington's Social and Health Services Provider Payment System

Provider Spenddown Step-by-Step

WHY

A person applies for Medicaid medical coverage and potentially qualifies for the Medically Needy (MN) program but has income above the MN limits. The client must incur financial obligations for medical expenses (spend down).

SPENDDOWN: Spenddown is like an insurance deductible. It's the process used to determine the client's liability for the cost of medical care. Clients must incur medical expenses equal to their excess income (spenddown or liability) before medical benefits are authorized. The spenddown liability is the client's financial obligation and can't be paid by the state. We compute the amount of the client's spenddown using a base period, consisting of three or six consecutive calendar months. Depending on when the client's incurred medical expenses meet the spenddown liability, the client may get medical benefits for all or part of the base period.

HOW

- For new clients have/help them complete an online application: https://www.washingtonconnection.org/home/ .
    - Record Tracking #
    - Once application is processed, clients will receive a letter describing their spenddown amount and their base period.
        i. Clients can request retro eligibility for 1-3 months prior to the application month to cover their bills incurred before applying for medical coverage
        ii. Clients must call DSHS customer service line if they would like to shorten the current base period from 6 to 3 months or change which months are included in the retro base period calculation.

- If a provider is assisting a client to have bills applied to the client's spenddown liability.
    - Fax bills to 1-888-338-7410 for urgent cases also call the DSHS provider line **1-800-394-4571**
        i. Urgent reasons are: Medication needed immediately, emergent medical condition or needs immediate doctor appointment.
    - Submit paid/unpaid bills (statements) within the client's base period
        i. Submit only unpaid bills incurred outside of the base period
        ii. Bills can be from any household family member living in the same home for which the client is financially responsible – e.g., (a spouse or a child's bills).
- Once the eligibility requirement is met clients will receive a letter describing eligibility.
    - The letter shows
        i. The amount of individual provider bills applied to the spenddown liability
        ii. The base period, and retro eligibility
        iii. Any bills not able to be used and why
- How providers know if a client has a spenddown liability.
    - Review the client eligibility screen in ProviderOne
    - Benefit Service Package showing **Pending Spendown-No Medical**, client is not eligible for Medicaid until spenddown liability is met. (Providers can bill the client)

Client Eligibility Spans

Service Type Code	Insurance Type Code	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group
30: Health Benefit Plan Coverage	MC: Medicaid	Pending Spenddown - No Medical	08/01/2011	12/31/2999	S99

PROVIDER BILLING

The client satisfies their spenddown liability and is now medical eligible.

- Client is on the **LCP-MNP** program
- The **ACES Coverage Group** code ends with a "99" (see above illustration).
- Client could have Retro coverage
- Providers must bill Medicaid for client services

When does a provider report the spenddown amount on a claim?

- If the claim "From" date of service is the same as the clients eligibility start date; or
- The claim was used to satisfy the spenddown.

What amount do providers report on their claim?

- Call **1-800-394-4571** to get the spenddown amount to report or get a copy of the client's award letter.
- If no spenddown reported on claim it will be denied.
- Spenddown must be reported accurately.
- The spenddown is subtracted from the service allowable and provider may be paid any difference.
- Client is only liable for the spenddown amount of the claim.

How does a provider report the spenddown amount on a claim?

A provider must report the spenddown amount on a claim.

A. Professional claim

- Electronic batch claims (837P)
  - HIPAA 5010, Loop 2300 in the
  - AMT Patient Amount Paid segment
  - Use value qualifier F5 in AMT01
  - Then enter the $$ amount in AMT02
- Paper Claim CMS-1500
  - In field 19, comments
  - Enter SCI=Y
  - Then enter the spenddown amount
- DDE Professional claim
  - In the **Claim Information** section
  - Under Claim Data
  - At the "+Additional Claim Data" section expand by clicking on the red plus
  - Enter the spenddown amount in the Patient Paid Amount field

B. Institutional claim

- Electronic batch claim (837I)
  - HIPAA 5010 Value Codes: Loop 2300 in the
  - Hi Value information segment
  - Value Code is 66 then enter spenddown amount
  - For an EMER also use Value Code 66, then amount (combine both into one value amount if appropriate)
- Paper claim UB-04
  - In form locator 39-41 (a-d) enter the value code and the amount
  - Use Value Code 66 (for spenddown and EMER)
  - Then enter the spenddown or EMER amount (combine if appropriate)
- DDE Institutional claim
  - At the **Claim Information** section expand the "+Value Information"
  - Enter the Value Code 66 (for spenddown and EMER)
  - Then enter the spenddown or EMER amount (combine if appropriate)

C. Dental Claim

- Electronic batch claim (837D)
  - HIPAA 5010 Spenddown: Loop 2300 in the
  - AMT Patient Amount Paid segment
  - Use value qualifier F5
  - The enter the $$ amount

- Dental paper claim enter the spenddown
  - In field 35, comments
  - Enter SCI=Y
  - Then enter the spenddown amount

- DDE Dental claim
  - Under **Claim Information**
  - At the "**+** Additional Claim Data" section expand by clicking on the red plus
  - Enter the spenddown amount in the Patient Paid Amount field

QMB-Medicare only clients

- May qualify for medical coverage if they meet a spenddown.
- **Would have QMB status thru the spenddown process**, Medicare is primary.
- Bill Medicare, then bill Medicaid the crossover claim
  - Medicaid may pay the crossover (depends on the Medicare payment).
  - Cannot bill the client for these balance amounts from crossover claims.
  - There is no spenddown amount to report on the crossover claim.
  - Balances not paid on the crossover claim are not applied to satisfying the spenddown liability.
- Services not covered by Medicare are used to satisfy the spenddown not the crossover claims.

Billing the Client

- Bill the client when the eligibility check shows "Pending Spenddown"
- Client becomes eligible for LCP-MNP Medicaid medical
  - Client is responsible for all bills used to satisfy spenddown
  - Report spenddown on claim as required
  - Client may become Retro eligible
- Once eligible all Billing the Client rules apply

Note for Nursing Homes. When billing for the patient participation on your institutional claim form use Value Code 31 with the participation amount in the value code form locators. If the patient also has a spenddown, enter the spenddown following the above institutional claim guidelines as a separate entry from a participation amount.